STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA OAHE MANOR	700 E GARFIELD , GETTYSBURG, South Dakota, 57442

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/3/25 through 9/4/25. Areas surveyed included potential neglect related to staff not using a transfer belt to transfer a resident which resulted in a bruise on the resident's arm, and an accident related to a resident fall which occurred as a result of a staff member who did not follow the resident's plan of care. Avera Oahe Manor was found not in compliance with the following requirement: F658	F0000		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to follow nursing professional standards to ensure one of one sampled resident (1) had consistent neurological checks completed and documented after the resident fell and hit her head, according to the provider's policies. Findings include: 1. Review of the 8/3/25 SD DOH FRI regarding resident 1 revealed: *On 8/3/25 at 12:00 p.m. resident 1 was walking with certified nursing assistant (CNA) E to the bathroom. *CNA E let go of resident 1's gait belt (a waist strap gripped as support for safe mobility and transfers) to turn on the bathroom light. *Resident 1 lost her balance, fell to the floor, and	F0658	DON educated CNA E on the need for gait belt use at all times per care plan on Resident 1. Education was completed on August 6 and August 7, 2025 LTC Fall Evaluation and Injury Prevention Policy was updated on September 22, 2025 to include neuro check components to be documented. DON will educate LPN F, LPN D, RN/IP B, LPN C, and nursing staff on the updated LTC Fall Evaluation and Injury Prevention Policy including the neuro check components to include with each neuro check assessment. Education will be completed by October 8, 2025. All residents are potentially at risk. Audits of neuro checks will be completed on residents that have falls with indication of neuro checks. DON or designee will conduct audits weekly for 2 months and monthly for 2 months. Audits will be discussed at monthly QAPI meetings and will be brought to quarterly QAPI committee meetings by DON or designee and reviewed for one year or until deemed no longer necessary.	October 8, 2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rena Robbennolt CNP	Administrator	9/22/25

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F0658 SS = D	Continued from page 1 hit her head on the floor. *Resident 1 was assessed by licensed practical nurse (LPN) F, who did not identify any injuries at that time. *Resident 1 was taken to the emergency room by her husband, who was present at the time of the fall. *While in the emergency department resident 1's husband declined a CT scan (imaging test that uses x-rays of cross sections of the body) of resident 1's head. 2. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 8/1/25. *Her 8/7/25 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. *Her diagnoses included Parkinson's (a disorder of the central nervous system that affects movement, often including tremors), weakness, dizziness on standing, and loss of balance. *Review of her admission care plan revealed on 8/1/25 an intervention was added to her care plan that indicated resident 1, "transfers and ambulates with staff assistance x1 [times one], a walker and [the use of a] gait belt." *Resident 1's 8/1/25 fall risk assessment, had a score of 2 which indicated she required "Standard fall precautions". *Resident 1 was admitted to the emergency room on 8/3/25 at 1:30 p.m. and discharged from the emergency department on 8/3/25 at 2:29 p.m. *She returned to the facility on 8/3/25 at 2:30 p.m. with a diagnosis of mild dehydration (loss of body fluid caused by illness, sweating, or inadequate intake), and was advised to increase her fluid intake. 3. Review of resident 1's post-fall neurological assessments (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) (neuros) revealed: *There were identified areas for assessment on the Neuro Check Care Assessment in resident 1's EMR which included:	F0658		

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F0658 SS = D	Continued from page 2 -“Neurological --Orientation --Behavior --Speech Patter” -“Glasgow Coma Scale [a neurological assessment tool used to evaluate the level of consciousness after a brain injury] --Eye opening --Verbal response --Motor response --Glasgow coma scale total score” -“Pupil Assessment --bilateral eyes --Pupil size (mm) [millimeters] --Pupil reaction --Pupil shape” -“Ocular [eye] Assessment --Eye movement --Tracking on horizontal plane --Tracking on vertical plane --Able to independently open and close eyelids” -“Visual Acuity --Peripheral visual fields intact --Blurry Vision” -“Neurological Symptoms -Dizziness/vertigo -Nausea/vomiting -Headache”	F0658		

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F0658 SS = D	Continued from page 3 -“Movement/Strength/Sensation --bilateral lower --Movement description --Strength description --Sensation description --bilateral upper --Movement description --Strength description --Sensation description”. *Resident 1's 8/3/25 12:00 p.m. neuro assessment taken immediately after the resident's fall did not have the “Pupil Assessment” or the “Movement/Strengths/Sensation” portions of the assessment completed. *Resident 1's 8/3/25 12:30 p.m. neuro assessment did not have the Glasgow Coma Scale, Pupil Assessment, Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed. *Resident 1's 8/3/25 1:00 p.m. neuro assessment did not have the Glasgow Coma Scale, Pupil Assessment, or the Movement/Strength/Sensation portions of the assessment completed. *Resident 1's next neuro assessment was completed on 8/3/25 at 5:00 p.m. and did not have the Glasgow Coma Scale, Pupil Assessment, Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed. *Resident 1's 8/3/25 9:00 p.m. neuro assessment did not have the Glasgow Coma Scale completed. *Resident 1's 8/4/25 1:04 a.m. neuro assessment did not have resident 1’s orientation, the Glasgow Coma Scale, bilateral lower sensation description, or bilateral upper sensation description. *Resident 1's 8/4/25 5:00 a.m. neuro assessment did not have the Glasgow Coma Scale completed.	F0658		

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F0658 SS = D	Continued from page 4 *Resident 1's 8/5/25 9:00 a.m. neuro assessment did not have the Glasgow Coma Scale completed. *Resident 1's 8/6/25 9:00 a.m. neuro assessment had every field in the neuro assessment completed. *Resident 1's 8/7/25 9:00 a.m. neuro assessment did not have the Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed. *Resident 1's 8/8/25 9:00 a.m. neuro assessment did not have the Glasgow Coma Scale completed. *Resident 1's 8/9/25 9:00 a.m. neuro assessment did not have the Glasgow Coma Scale, Pupil Assessment, Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed. *Resident 1's 8/10/25 9:00 a.m. neuro assessment did not have the pupil size, Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed. *Resident 1's 8/11/25 9:00 a.m. neuro assessment did not have the Glasgow Coma Scale, or the pupil size completed. 4. Interview on 9/3/25 at 2:15 p.m. with LPN D revealed: *Neuro assessments were to be completed anytime a resident fell and hit their head. *She would check the resident's pupils, make sure the resident could follow commands, and check their strength in their upper and lower extremities. *There was a post-fall worksheet that the nursing staff followed so they would know what needed to be done after a resident fell and how often the resident's vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) needed to be taken and when the neuro assessments were to be completed. 5. Interview on 9/3/25 at 2:56 p.m. with registered nurse (RN)/infections preventionist (IP) B revealed: *Each of the areas identified on the Neuro Check Care Assessment form was visible to the nurse who was completing the resident's neuro assessments.	F0658		

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F0658 SS = D	Continued from page 5 *RN/IP B verified resident 1's documented neuro assessments completed after she fell, had areas that were completed were blank or not completed. 6. Interview on 9/3/25 at 3:10 p.m. with RN/IP B and LPN C revealed: *They felt the expectations were not clear regarding what needed to be charted related to in the residents' neuro assessments because when one identified area on the Neuro Check Care Assessment was completed, the neuro assessment task was able to be documented as completed in the EMR system. *RN/IP B's expected that the residents' Neuro Check Care Assessments were to be completed as thoroughly as possible. *They stated that it would not be possible to identify if there was a change in a resident's neurological status if the neuro assessments and documentation of those assessments were not complete. 7. Interview on 9/4/25 at 11:10 a.m. with administrator A revealed: *She expected the documentation on the Neuro Check Care Assessment form would be completed consistently. *She verified the documentation in resident 1's post-fall Neuro Check Care Assessments were not completed consistantly. 8. Review of the provider's undated Post Fall Worksheet revealed: "*If [a] resident hit [their] head, or if [a] fall is not witnessed and [the] resident is unable to tell you if they hit their head, Neuro checks need to be completed as below, in addition to vital signs." -"Initially after the fall, every 30 minutes times two, every four hours times four, and daily times seven." Review of the provider's February 2024 Fall Evaluation and Injury Prevention policy revealed: *"Resident fall… -c. Assessment of the resident will continue at least every shift for the next 72 hours. --a. Reassessments should include vital signs,	F0658		

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F0658 SS = D	Continued from page 6 neurological assessments, review of systems as well as worsening or improving symptoms as well as any treatment provided. -d. If the resident hit their head or the fall was unwitnessed and the resident is not able to communicate if they hit their head, staff will complete the Neurological Assessment-LTC [long-term care] at least every 4 hours x [times] 4 then daily x 72 hours."	F0658		